STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445260	A. BUILDING _____ B. WING _____	04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH CARE CENTER	100 ELMHURST DR OAK RIDGE, TN 37830

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview the facility failed to notify the	F 157	**This Plan of Correction is prepared and executed because it is required by the provisions of State and Federal law, and not because Briarcliff Healthcare Facility agrees with allegation(s) and citation(s) listed on this Statement of Deficiencies. Briarcliff Healthcare Facility maintains that the alleged deficiencies do not individually or collectively constitute substandard care or jeopardize the health and safety of the residents; nor are they of such character so as to limit our capability to render adequate care. This Plan of Correction shall also serve as the facility's written Credible Allegation of Compliance.** F-157 RI # 103 responsible party was notified of change of condition related to pressure ulcer. Charge nurse was re-educated by the DON regarding notifying responsible party for resident change in condition. All residents with a change of condition within the last 3 months will be reviewed by the Risk Manager to ensure that appropriate notification occurred. All other licensed staff will be educated by staff development coordinator related to notifying responsible party of resident change in condition. The unit managers will review the 24 hour report during the morning meeting to ensure compliance with notification of resident change in condition.	05-19-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jodi Jones — Administrator — 5-1-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 responsible party with a change in the resident's condition for one resident (#103) of thirty four residents reviewed. The findings included: Resident #103 was admitted to the facility on February 2, 2012, with diagnoses including Diabetes Mellitus, Intracerebral Hemorrhage, and Hypertension. Medical record review of a Skin Check dated April 18, 2012, revealed the resident developed three stage two pressure ulcers on the left buttocks, right buttocks, and coccyx. Observation with the West Wing Unit Coordinator on April 18, 2012, at 10:30 a.m., in the resident's room, revealed the resident had dark reddened open areas on bilateral buttocks and coccyx. Interview on April 19, 2012, at 8:20 a.m., with the West Wing Unit Coordinator, in the West Wing Nurse's Station, confirmed the facility failed to notify the responsible party of a change in the resident's condition.	F 157	The DON or designee will randomly monitor any residents with a change in condition to ensure that the appropriate parties were notified. Results will be discussed monthly for 3 months in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance. F-159 The facility will ensure funds for residents #35 and #79 are available 7 days a week. Funds will be available for all residents 7 days a week. The Director of Social Services will completed random interviews with alert and oriented residents to identify any other resident concerns related to availability of Resident Trust Funds.	05-19-12
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of	F 159	The facility business office will be open 7 days a week to ensure that resident funds are accessible. All residents and staff will be educated by Staff Development Coordinator and/or Director of Social Services related to resident trust availability 7 days a week.	

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F 159	Continued From page 2 the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by:	F 159	The Director of Social Services or designee will randomly interview alert and oriented residents for 4 weeks to ensure compliance. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	

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F 159	Continued From page 3 Based on observation, review of the facility's Trust Funds, facility policy review, and interview, the facility failed to ensure resident funds were available on the weekend for two (#35 and #79) of thirty-four residents reviewed. The findings included: Observation and interview with resident #35 on April 16, 2012, at 1:56 p.m., revealed the resident sitting on the bed. Interview, at this time revealed the resident was unable to obtain money from the resident trust fund account on the weekends. Observation and interview with resident #79 on April 17, 2012, at 8:04 a.m., revealed the resident sitting in a wheelchair in the day room. Interview, at this time revealed the resident was unable to obtain money from the resident trust fund account on the weekends. Review of the facility's Trust Fund Trial Balance revealed resident #35 and #79 had funds in a Trust Fund account. Review of the facility policy Resident Trust revealed "...The facility will maintain a $150.00...petty cash fund, used specifically for withdrawals of cash for residents on a daily basis..." Interview with Bookkeeper #1, on April 19, 2012, at 9:30 a.m., in the Bookkeeper's office, revealed when residents needed access to money from their resident trust account, they requested the money from the administrative assistant/receptionist. Continued interview revealed money from the resident's trust fund	F 159		

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F 159	Continued From page 4 accounts were only dispersed by business office personnel. Continued interview revealed staff members from the business office did not work on weekends and confirmed the residents did not have access to their money in the trust fund accounts on the weekend.	F 159	F-166 Grievances for residents # 55 and # 96 were resolved on 4-19-2012. The Director of Social Services has reviewed the grievance log and no other issues were identified. The Director of Social Services was re-educated by the Administrator on 4-20-2012 regarding resident's right to prompt efforts to resolve grievances. The Director of Social Services will review all grievances daily 5 times a week during the morning meeting to ensure that all grievances are resolved promptly. The Director of Social Services will review the grievance log monthly and the results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records, and Administrator for Quality Assurance.	5-19-12
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on facility policy review, facility grievance log review,and interview the facility failed to resolve a grievance timely for two residents (#55 and #96) of 34 resident's reviewed. The findings included: Resident #55 was readmitted to the facility on September 15, 2010, with diagnosis including Multiple Sclerosis, Urinary Tract infections, and Sepsis. Medical record review of the Minimum Data Set (MDS) dated February 5, 2012, revealed the resident was independent with daily decision making. Interview with resident #55 on April 16, 2012, at 3:27 p.m., in the resident's room, revealed the resident had filed a formal grievance with the facility on December 28, 2012, due to money the	F 166		

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F 166	Continued From page 6 resident found missing following a Leave of Absence for the evening. The resident stated the money was kept in a lock box in her bedside table. The resident reported that the lock box and it's contents were missing upon return to the facility. Review of the facility grievance log revealed the grievance had been filed on December 28, 2011, as described during the resident interview. Review of the facility policy regarding grievances revealed,"...The facility shall investigate and resolve all complaints/concerns/grievances promptly...11.In resolving the complaint/concern/grievance, both the Administrator and the complaintant shall develop a plan of action which shall be specific about what is to occur...the plan of action will be implemented immediately..." Review of the facility Complaint/Grievance Form, dated December 28, 2011 revealed the Administrator contacted the resident and the resident's spouse to investigate the report.The room was searched by staff, the local police were notified and an officer responded to investigate. The missing items were not found. Continued review of the facility Grievance Form revealed on December 30, 2011, the Administrator advised the resident and spouse the money would be returned and maintenance installed a new lock box and bolted it to the drawer of the bedside table. The Administrator closed the grievance as resolved with resident and spouse satisfied on January 3, 2012. Interview with resident #55 on April 17, 2012, at	F 166		

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F 166	Continued From page 6 4:00 p.m., revealed the lock box had been installed but the missing money had not been returned. Interview with the Administrator on April 18, 2012, at 7:20 a.m., in the conference room, confirmed the grievance had been closed prior to returning the resident's money ($87.00). The money was not returned to the resident until April 18, 2012. The Administrator further confirmed the grievance had not been resolved timely. Resident #96 was admitted to the facility on March 14, 2012, with diagnoses including Atrial Fibrillation, Wound Left Ankle, and Depression. Review of the Minimum Data Set Assessment dated March 21, 2012, revealed the resident is cognitively intact, and capable of making own decisions. Interview with resident #96 on April17, at 3:20 p.m., in the resident's room, revealed the resident reported to the staff a cell phone was missing two weeks after admission to the facility and the Social Service Director had discussed the missing cell phone with the resident. Further interview revealed the cell phone was still missing and no one had followed up with the resident regarding the missing cell phone. Review of the facility grievance log March 2012, and April 2012, revealed no grievance had been filed as described during the resident interview. Interview with the Social Service Director on April 18, 2012, at 1:00 p.m., in the conference room confirmed the facility failed to investigate or	F 166		

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F 166	Continued From page 7 resolve the grievance.	F 166	F-241 RN #1 was re-educated by the DON regarding providing privacy to maintain dignity while providing care. All licensed staff will be re-educated by the Staff Development Coordinator regarding providing privacy to maintain dignity during care. The Staff Development Coordinator will completed random rounds for 4 weeks to determine compliance. Results will be reviewed weekly during the focus meeting comprised of the DON, Risk Manager, East and West Unit Managers, Wound Care Nurse Restorative Nurse, Dietary Manager, Social Services Director and Staff Development Coordinator for 6 weeks to ensure compliance. The DON or designee will complete random rounds to ensure compliance with privacy and dignity. Results will be discussed monthly for 3 months in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	5-19-12
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote care that maintained or enhanced dignity during a skin assessment for one resident (#174) of thirty-four residents reviewed. The findings included: Resident #174 was admitted to the facility on December 16, 2011, with diagnoses including History of Falls, Diabetes Mellitus, Dementia, Dysphagia, and Parkinsons. Observation in the resident's room on April 18, 2012, at 10:46 a.m., revealed the Registered Nurse (RN) #1 performed a skin assessment to the resident's lower extremities, with the resident seated in a wheelchair, near the doorway, visible to the hallway, without closing the door. Interview with RN #1 in the West Wing Nurse's Station, on April 18, 2012, at 10:55 a.m., confirmed the facility failed to maintain or enhance dignity during a skin assessment for resident #174.	F 241		
F 247	483.15(e)(2) RIGHT TO NOTICE BEFORE	F 247		

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F 247 SS=D	Continued From page 8 ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility documentation review, review of the Facility Resident Handbook, and interview the facility failed to notify Resident #78 of roommate changes prior to implementing the room assignment changes. The findings included: Resident #78 was re-admitted to the facility on January 10, 2012, with diagnoses including History of Falls, Diabetes with Peripheral Neuropathy, and Cerebrovascular Disease. Interview with resident #78 on April 16, 2012, at 10:48 a.m., in the resident's room, revealed the resident had roommate changes on two seperate occasions without prior notification by the facility. Interview with the resident on April 18, 2012, at 3:10 p.m., in the resident's room, revealed the resident had shared a room with spouse, until the spouse was discharged. The facility advised the resident that upon the spouse's discharge, resident #78 would be relocated to room 204 where "... there would be more space and privacy because, in the new room assignment, there was no roommate..." Continued interview revealed, resident #78 was surprised the next day, when a	F 247	F-247 Director of Social Services discussed the resident's rights to receive notification before the resident's room or roommate in the facility is changed with resident #78 and communicated departments plan for continued compliance. Interviews were conducted by Director of Social Services or designee with other residents to identify any additional concerns with notification of resident's room or roommate change and no other issues were identified. All new admissions and room changes will be discussed daily 5 times a week during the morning meeting. The Director of Social Services or designee will notify residents or resident's responsible party prior to room or roommate change. The Director of Social Services will review new admissions and room changes weekly for 4 weeks. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	5-19-12

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F 247	Continued From page 9 roommate arrived with no prior notification from the facility. The resident further stated that when the roommate was discharged a few weeks later, again, a roommate was moved into the resident's room without prior notification by the facility. The interview also revealed the resident was unaware the bathroom was shared with three other residents "...found that out on my own one morning...surprise..." The facility failed to advise the resident the bathroom was a shared bathroom for two rooms and four residents. Medical record review of the Social Services notes from the admission date (January 10, 2012) to April 18, 2012, regarding resident #78 revealed no documentation the facility had provided prior notification of roommate changes prior to implementation of the changes. Medical record review of the nurses notes from January 10, 2012, through April 18, 2012, revealed there was no documentation of prior notification by the facility, of imminent roommate changes for resident #78. Review of the Facility's Resident Handbook, provided to and reviewed with resident's/or resident's representatives on admission, revealed "...Resident Rights...1.You have the right to receive notice before you are transferred to another room or before you receive a new room mate..." Interview with the Social Services Director on April 18, 2012, at 5:05 p.m., in the Social Services Office, revealed the Social Services Department handles in-house transfers and/or room assignment changes. Continued interview	F 247		

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F 247	Continued From page 10 revealed there was no documentation of any prior notification of roommate changes for resident #78. Interview with the Administrator on April 19, 2012, at 10:00 a.m., in the Administrator's office, revealed the facility failed to follow their own policy regarding room assignments, and resident #78 had the right to be informed of the roommate changes prior to the transfers.	F 247	F-278 The MDS for residents #94, #20, #86, and #174 were updated by the MDS Coordinators to reflect the resident's current status related to pressure ulcers, bladder continence, visual status, eating/feeding status and falls. All other resident's current MDS's were reviewed and updated by MDS Coordinators as needed to reflect the resident's current status. The Interdisciplinary Care Plan Team comprised of the Risk Manager, Wound Care Nurse Restorative Nurse, Dietary Manager, Social Services Director and Activities Director was in-serviced by the Regional MDS Specialist on 5-3-12 related to accurate completion of MDS. The DON or designee will randomly monitor 4 MDS's per week for 6 weeks to assure they are reflective of resident's current status. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	05-19-12
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		

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F 278	Continued From page 11 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to comprehensively assess pressure ulcer status for one resident (#94), bladder continence status for two residents (#20 and #86), visual status for one resident (#86), eating/feeding status for one resident (#174), and falls for one resident (#174) of thirty-four residents reviewed. The findings included: Resident #94 was admitted to the facility on December 23, 2011, with diagnoses including Fractured Neck of Femur, Dysphagia, and Depressive Disorder. Medical record review of the Minimum Data Set (MDS) dated December 30, 2011, revealed the resident was admitted with two unstageable pressure ulcers, and the resident was at risk for the development of pressure ulcers. Medical record review of the MDS dated March 23, 2012, revealed the resident had one unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar present upon admission (right heel) and one unstageable pressure ulcer with suspected deep tissue injury (sacrum). Medical record review of a skin check dated March 22, 2012, revealed "...Red area: center of	F 278		

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	445260	A. BUILDING _____ B. WING _____	04/19/2012

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F 278	Continued From page 12 spine..." Observation of the resident and interview in the resident's room on April 18, 2012, at 9:45 a.m., with the West Wing Unit Coordinator revealed a wound on the right lateral foot described as follows: right lateral foot pressure ulcer unstageable eschar measuring 1.4 cm (centimeter) x 1.8 cm. Observation on April 19, 2012, at 9:25 a.m., with the Licensed Practical Nurse (LPN) wound care nurse revealed the resident lying in the bed. Continued observation revealed a wound to the right upper back described by the LPN wound care nurse as follows: right upper back pressure ulcer eschar measuring 3 cm x 2.5 cm with red peri-wound. Interview on April 19, 2012, at 11:25 a.m., in the conference room, with the MDS Coordinator #1, confirmed the MDS completed on March 23, 2012 was inaccurate and did not reflect the pressure ulcer on the right lateral foot and right upper back. Resident #20 was admitted to the facility on November 10, 2012, with diagnoses including: Post Traumatic Right Hip Fracture, Fracture of the Right Scapula and Clavicle and Renal Insufficiency. The resident was discharged home on February 3, 2012. Medical record review of the MDS assessment dated November 10, 2011, revealed the resident was continent of bowel and bladder. Medical record review of the MDS assessments dated November 30, 2011, and January 3, 2012,	F 278		

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F 278	Continued From page 13 revealed the resident continued to be continent of bowel and bladder. Medical record review of the MDS assessment completed on February 1, 2012, revealed "...always incontinent...no episodes of continent voiding." Medical record review of the Daily Skilled Nurses Notes from November 10, 2011 through February 3, 2012, revealed no documentation resident #20 was incontinent or documentation the resident required incontinence care during rehabilitation. Medical record review of the Nurse's Discharge Summary dated February 3, 2012, revealed "...continent of bowel and bladder...no GU (genito-urinary) issues." Medical record review of the resident's Care Plans from November 10, 2011 through February 3, 2012, did not include interventions for incontinence or incontinence care. Interview with the Regional Minumum Data Set Coordinator, on April 18, 2012, at 8:45 a.m., in the conference room, confirmed the MDS dated February 1, 2012, did not accurately reflect the resident's voiding status. Resident #86 was admitted to the facility on November 11, 2011, with Diagnoses including Diabetes with Peripheral Neuropathy, Mood Disorder with Behaviors, and Chronic Kidney Disease. Medical record review of the MDS dated April 15, 2012, revealed the resident was cognitively intact. The MDS further revealed the resident had visual	F 278		

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F 278	Continued From page 14 deficits and "could not read print..." The MDS reflected the resident's bladder status as incontinent. Medical record review of the Daily Skilled Nurses Notes from November 1, 2011 to April 18, 2012, reflected the resident's bladder status as "continent with breifs." Observation on April 18, 2012, at 9:55 a.m., in the resident's room, revealed the resident awake, in bed watching t.v. The bedside table was on the left side of the bed, with a urinal on the table within the resident's reach. Interview with the resident, at the time of the observation, revealed the resident uses the urinal w/out (without) difficulty and has only experienced occasional "accident...when just couldn't get there in time..." Interview with Certified Nursing Assistant (CNA) #1 and CNA #2 on April 18, 2012, outside the resident's room, immediately following the resident observation and interview, confirmed the resident was able to use the urinal without difficulty. Both CNAs stated the resident is continent with only rare episodic incontinence. Interview with LPN #1, on April 18, 2012, at 10:08 a.m., in the 100 hall, revealed the resident was incontinent. LPN #1 confirmed there were inconsistencies with the documentation related to the resident's bladder status and further stated the nursing assessments were entered daily by the LPN assigned to the hall, and the CNA's documentation related to daily urinary output (Void Report Roster) were entered seperately by the CNAs.	F 278		

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F 278	Continued From page 15 Interview with the Director of Nursing (DON), on April 18, 2012, at 10:25 a.m., outside the DON's office, confirmed there were multiple inconsistencies related to the resident's continence assessments and the daily care provided to resident #86. Continued review of the resident's MDS dated November 10, 2011, and January 22, 2012, revealed the resident was coded for visual deficits, and the resident was unable to read print. Medical record review of the Nurses Notes from November 10, 2011 through April 18, 2012, did not identify visual deficits. Medical record review of the resident's Care Plans from November 10, 2011 through April 18, 2012, revealed no Care Plan related to visual deficits. Interview with resident #86 on April 18, 2012, at 10:08 a.m., in the resident's room, revealed the resident denies visual deficits, and the resident stated "...don't need glasses..." The resident further stated that much of the day is spent on the computer, on facebook, without difficulty reading print. Interview with the Regional Minumum Data Set Coordinator, on April 18, 2012, at 11:05 a.m., in the conference room, confirmed the MDS Assessments dated November 10, 2011, and January 22, 2012, were not accurate related to the resident's visual status. Resident #174 was admitted to the facility on December 16, 2011, with diagnoses including	F 278		

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F 278	Continued From page 16 History of Falls, Diabetes Mellitus, Dementia, Dysphagia, and Parkinsons. Medical record review of the MDS dated February 16, 2012, revealed the resident had not experienced any falls since last MDS assessment dated February 3, 2012. Medical record review of a Supplemental Screening of Resident Falls dated February 17, 2012, revealed the resident had a fall with no injury on February 13, 2012. Medical record review of the MDS dated March 11, 2012, revealed the resident was totally dependent for eating. Observation on April 18, 2012, at 8:05 a.m., in the resident's room, revealed the resident sitting in a wheel chair feeding self with a curved spoon and a divided plate. Interview with Certified Nurse Aide #3 on April 18, 2012, at 8:42 a.m., in the resident's room, revealed the resident feeds self after the tray is set up. Interview with Speech Therapist #1 on April 18, 2012, at 9:30 a.m., in the therapy room, revealed the resident feeds self after the tray is set up. Interview with MDS Coordinator #2 on April 18, 2012, at 9:40 a.m., in the Care Plan Office, confirmed the facility failed to complete a Comprehensive MDS Assessment to include the fall and did not reflect the resident's current level of independent eating.	F 278		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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F 279 SS=D	Continued From page 17 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan to include the pressure ulcers on the right lateral foot, and right upper back for one (#94) resident and failed to revise the careplan for a urinary catheter for one (#103) and failed to review the care plan to address range of motion for one (#86) of thirty-four residents reviewed. The findings included: Resident #94 was admitted to the facility on	F 279	**F-279** Care plans of residents #94, #103, and #86 were revised by MDS Coordinators to reflect the resident's current status related to pressure ulcers, catheters and range of motion. All other care plans were reviewed by MDS Coordinators to assure they are reflective of resident's current status related to pressure ulcers, catheters, and range of motion. The Interdisciplinary Care Plan Team comprised of the Risk Manager, Wound Care Nurse Restorative Nurse, Dietary Manager, Social Services Director and Activities Director was in-serviced by the Regional MDS Specialist on 5-3-12 related to assuring resident care plans are reflective of resident's current status. The DON or designee will randomly monitor care plans of 5 residents' weekly for 4 weeks to ensure accuracy. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	05-19-12

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F 279	Continued From page 18 December 23, 2011, with diagnoses including Fractured Neck of Femur, Dysphagia, and Depressive Disorder. Medical record review of the Minimum Data Set dated December 30, 2011, revealed the resident was admitted with two unstageable pressure ulcers. Medical record review of the care plan reviewed on March 29, 2012, revealed no documentation of the pressure ulcers on the right lateral foot and right upper back. Observation and interview on April 18, 2012, at 9:45 a.m., in the resident's room, revealed the West Wing Unit Coordinator described the wound on the right lateral foot as follows: right lateral foot pressure ulcer unstageable eschar measuring 1.4 cm (centimeters) x 1.8 cm. Observation on April 19, 2012, at 9:25 a.m., with the Licensed Practical Nurse (LPN) wound care nurse revealed the resident lying on the bed. Continued observation revealed a wound to the right upper back described by the LPN wound care nurse as follows: right upper back pressure ulcer eschar measuring 3 cm x 2.5 cm with red peri-wound. Interview on April 19, 2012, at 8:15 a.m. with the Director of Nursing (DON) in the conference room, confirmed the care plan was not revised to include the pressure ulcer on the right lateral foot and right upper back. Resident #103 was readmitted to the facility on January 10, 2012, with diagnoses including	F 279		

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F 279	Continued From page 19 Diabetes Mellitus, Hypertension, Malaise, Cerebral Vascular Accident, and History of Pulmonary Embolus. Medical record review of a Physician Telephone Order dated April 15, 2012, revealed "...insert urinary cath...Dx: (diagnosis) Urinary Retention..." Medical record review of the current Interdisciplinary Care Plan dated January 23, 2012, revealed the care plan had not been revised to reflect the resident's urinary catheter. Interview with the Minimum Data Set (MDS) Coordinator on April 17, 2012, in the MDS Office, confirmed the facility failed to update the care plan to reflect the urinary catheter. Resident #86 was admitted to the facility on March 13, 2009, and readmitted on November 10, 2011, with diagnoses including Cerebrovascular Accident with Right Sided Hemiparesis, Hypertension, Diabetes, Mood Disorder, Depression, Hyperlipidemia, Chronic Kidney Disease, History of Atrial Fibrillation, and Insomnia. Medical record review of the Minimum Data Set (MDS) dated January 22, 2012, revealed the resident had limitation in functional range of motion in the upper and lower extremity on one side. Medical record review of the of the Care Plan updated on January 27, 2012, revealed no interventions/approaches to address the limitation in range of motion of the upper and lower extremities.	F 279		

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F 279	Continued From page 20 Observation on April 18, 2012, at 2:30 p.m., revealed the resident seated in a wheelchair in the therapy department with the right arm resting on the chest. Interview on April 18, 2012, at 3:05 p.m., with Corporate Nurse #1, in the MDS office, confirmed the Care Plan did not address the resident's limitation in range of motion to the right side.	F 279	F-314 A body audit was completed on resident #94 by Wound Nurse on 4-18-2012 to assure all pressure areas are identified, assessed and appropriate treatment orders are in place. Complete body audits were completed on all facility residents by the Nursing Administration Team on 4-26-2012 to assure all pressure areas are identified assessed, and appropriate treatment orders are in place and no other issues were identified.	6-3-12
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, observation, and interview, the facility failed to identify, assess, and treat pressure ulcers resulting in harm for one (#94) of thirty-four residents reviewed. The findings included: Resident #94 was admitted to the facility on December 23, 2011, with diagnoses including Fractured Neck of Femur, Dysphagia, and Depressive Disorder.	F 314	The Wound Nurse will review weekly body audits of current resident's and will complete body audits on all new admissions to assure all pressure areas are identified, assessed, and appropriate treatment orders are in place. The DON or designee will review all new admissions for completion with 24 hours. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	

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F 314	Continued From page 21 Medical record review of the Minimum Data Set dated December 30, 2011, revealed the resident was admitted with two unstageable pressure ulcers and the resident was at risk for the development of pressure ulcers. Medical record review of the care plan reviewed on March 29, 2012, revealed "...I need two persons to assist with repositioning to avoid skin friction/shearing..." Medical record review of a Nursing Note dated December 23, 2011, revealed "...On 12-23-11 at 10:45 am resident arrived via ambulance...skin assessment: multiple bruises to upper and lower left and right arm. Large bruises on left and right top of hand. Buttocks red (but) blanchable...Right heel black (pressure ulcer #1)..." Medical record review of a Physician's Order dated December 23, 2011, revealed "...Duoderm to (right) heel cleanse (with) wound cleaner then apply duoderm. Change q (every) 5 days (and) prn (as needed)..." Medical record review of a wound assessment dated December 29, 2011, revealed "...Date first observed: 12-23-11...Location: Right Heel...Stage: Unstageable...Length (in cm (centimeters)) 2.0...Width (in cm) 2.0...Wound bed tissue: Necrotic tissue...Drainage: None...Odor: None..." Medical record review of a wound assessment dated January 13, 2012, revealed "...Date first observed: 12-23-11...Location: Right Heel (pressure ulcer #1)...Stage: Unstageable...Length	F 314		

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F 314	Continued From page 22 (in cm) 2.0...Width (in cm) 2.0...wound bed tissue: Necrotic tissue...Drainage: None...Odor:...None..." Medical record review of a wound assessment dated March 29, 2012, revealed "...Date first observed: 12-23-11...Location: Right heel (pressure ulcer #1)...Stage: Unstageable...Length (in cm) 2.2...Width (in cm) 2.0...Wound bed tissue: Necrotic tissue...Drainage: None...Odor: None..." Medical record review of the Care Plan reviewed on March 29, 2012, revealed "...weekly evaluation of wound healing..." Interview on April 18, 2012, at 5:20 p.m., with the Director of Nursing (DON) in the conference room confirmed no wound assessments had been completed from January 13, 2012 until March 29, 2012, and from March 29, 2012, until April 18, 2012, on the right heel (pressure ulcer #1). Medical record review of the treatment record dated December 2011 revealed no documentation of treatment to the right heel pressure ulcer for the month of December, 2011 (pressure ulcer #1). Medical record review of the treatment record dated January 2012 revealed no documentation of treatment to the right heel pressure ulcer (pressure ulcer #1) until January 10, 2012. Medical record review of a Physician's Order dated January 10, 2012, revealed "...D/C (discontinue) Duoderm. Apply skin prep to bilateral heels once daily until healed..."	F 314		

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F 314	Continued From page 23 Interview on April 19, 2012, at 8:15 a.m., with the Director of Nursing (DON), in the conference room, confirmed the treatment to the right heel (pressure ulcer #1) had not been initiated until January 10, 2012. Medical record review of a Nurse's Note dated March 6, 2012, revealed "...6 cm x 5 cm unstageable non-blanchable dark area noted on sacrum (pressure ulcer #2) just left of the midline. (Nurse Practitioner) notified. New orders received to cleanse with wound cleanser. Pat dry. Apply duoderm... every 3 days..." Medical record review of a Physician's Order dated March 6, 2012, revealed "...cleanse sacral area pressure sore (pressure ulcer #2) with wound cleanser. Pat dry. Apply duoderm...dressing every 3 days until healed..." Medical record review of a Physician's Order dated March 16, 2012, revealed "...D/C (discontinue) treatment to sacral area (pressure ulcer #2)...Leave sacral wound open to air without any dressing daily..." Medical record review of a wound assessment dated March 29, 2012, revealed "...Date first observed: 3-6-12...Location: Sacrum (pressure ulcer #2) left of midline...Stage: Unstageable...Length (in cm) 6.0...Width (in cm) 5.0...Wound bed tissue: Necrotic tissue...Drainage: Sero-sanguinous...Odor: Mild..." Medical record review of the skin check dated April 18, 2012, revealed, "...(left) buttock	F 314		

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BRIARCLIFF HEALTH CARE CENTER	100 ELMHURST DR OAK RIDGE, TN 37830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24 (pressure ulcer #2) unstageable 8.1 x 11.4 x 0.9 (with) 2.6 cm tunneling...75% slough..." Interview on April 18, 2012, at 5:20 p.m., with the DON, in the conference room, confirmed no wound assessments had been completed from March 29, 2012 until April 18, 2012, on the sacrum pressure ulcer (pressure ulcer #2). Medical record review revealed there were no wound assessments for a pressure ulcer on the right lateral foot (pressure ulcer #3). Interview on April 18, 2012, at 5:20 p.m., with the DON, in the conference room, confirmed there were no wound assessments on the right lateral foot pressure ulcer indicating when the pressure ulcer was identified (pressure ulcer #3). Review of the facility policy, Wound Management Guidelines, revealed "...The nurse will identify the impairment and stage if indicated...Complete treatment record..." Medical record review of the Treatment Records dated January 2012, through April 18, 2012, revealed no treatment for the pressure ulcer on the right lateral foot (pressure ulcer #3). Medical record review revealed the Care Plan reviewed on March 29, 2012, had not been updated to include the pressure ulcer on the right lateral foot. Interview on April 19, 2012, at 8:15 a.m., in the conference room, with the DON, confirmed there were no physician's orders to treat the pressure ulcer on the right lateral foot (pressure ulcer #3).	F 314		

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F 314	Continued From page 25 Observation on April 18, 2012, at 9:45 a.m. revealed the West Wing Unit Coordinator providing wound care to the resident's pressure ulcer on the left buttock (pressure ulcer #2). Continued observation revealed the West Wing Unit Coordinator described the wound as follows: Unstageable pressure ulcer measuring 8.1 cm x 5.8 cm x 0.9 cm with 2.6 cm tunneling, with 75% slough. Continued observation revealed the West Wing Unit Coordinator described the wound on the right heel (pressure ulcer #1) and right lateral foot (pressure ulcer #3) as follows: Unstageable eschar pressure ulcer on the right heel measuring 2.3 cm x 1.5 cm, right lateral foot pressure ulcer unstageable eschar measuring 1.4 cm x 1.8 cm. Medical record review of a skin check dated March 22, 2012, revealed "...Red area: center of spine (pressure ulcer #4)..." Medical record review revealed there were no wound assessments for a pressure ulcer on the right upper back (pressure ulcer #4). Interview on April 19, 2012, at 8:15 a.m. with the DON, in the conference room, confirmed there were no wound assessments on the right upper back wound (pressure ulcer #4). Medical record review revealed the Care Plan reviewed on March 29, 2012, had not been updated to include the pressure ulcer on the right upper back. Medical record review of a Physician's Order dated April 15, 2012, revealed "...clean area	F 314		

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F 314	Continued From page 26 (right) mid back (pressure ulcer #4) (with) wc (wound cleanser) (and) cover (with) dry dsg (dressing) (change) qd (everyday)..." Medical record review of the Care Plan reviewed on March 29, 2012; revealed "...float heels on my pillow as needed..." Observation on April 19, 2012, at 8:00 a.m, with the West Wing Unit Coordinator revealed the resident lying on the right side in the bed without the heels floated. Continued observation revealed a wound to the upper right back (pressure ulcer #4). Interview at this time with the West Wing Unit Coordinator confirmed was not aware of the wound on the right upper back. Observation on April 19, 2012, at 9:25 a.m., with the Licensed Practical Nurse (LPN) wound care nurse revealed the resident lying in the bed. Continued observation revealed a wound to the right upper back (pressure ulcer #4) described by the LPN wound care nurse as follows: right upper back pressure ulcer eschar measuring 3 cm x 2.5 cm with red peri-wound. The resident was admitted on December 23, 2011, with a pressure ulcer to the right heel. Since admission the resident developed a pressure ulcer on the left buttock identified on March 6, 2012, a pressure ulcer on the right upper back identified on April 15, 2012, and a pressure ulcer on the right lateral foot with no wound assessments identifying when the pressure ulcer developed. The facility failed to consistently assess and treat the pressure ulcers. Medical record review of a Physician's Progress Note dated April 18, 2012, revealed "...Multiple	F 314		

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F 314	Continued From page 27 inevitable wounds..." Interview on April 19, 2012, at 9:55 a.m., in the conference room, with the DON, confirmed the Nurse Practitioner was aware of all of the wounds.	F 314	F-315 A bladder assessment was completed on resident #174 by Restorative Nurse on 5-1-2012 and placed on a toileting schedule on 5-1-2012. Bladder assessments will be completed on all other incontinent residents by Restorative Nurse and toileting schedules will be initiated if indicated. The Restorative Director was in-serviced by Regional Quality Assurance Nurse on 5-20-2012, related to bladder assessments to be completed on all incontinent residents and toileting schedules to be initiated if indicated. The DON or designee will monitor weekly for 4 weeks during weekly focus meeting. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	5-19-12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement an individualized bladder training program for one resident (#174) of thirty-four residents reviewed. The findings included: Resident #174 was admitted to the facility on December 16, 2011, with diagnoses including History of Falls, Diabetes Mellitus, Dementia, Dysphagia, and Parkinson's. Medical record review of the Minimum Data Set (MDS) dated December 30, 2011, revealed the resident was occasionally incontinent of urine on admission.	F 315		

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F 315	Continued From page 28 Medical record of the MDS dated March 11, 2012, revealed the resident was frequently incontinent of urine. Observation on April 17, 2012, at 10:00 a.m., in the resident's room, revealed the Certified Nurse Aide (CNA) #3 provided incontinence care to the resident. Interview with CNA #3 on April 18, 2012, at 8:42 a.m., in the resident's room, confirmed the resident was continent at times and was not on a scheduled toileting program. Interview with Corporate Nurse #2 on April 18, 2012, at 8:40 a.m., in the conference room, confirmed a bladder assessment had not been completed for the resident and confirmed a bladder training program had not been implemented to restore or improve bladder continence.	F 315	F-323 Safety device for resident #81 was put in place 4-19-2012. All other residents requiring safety devices were checked by Risk Manager on 4-19-2012 and all other safety devices were in place. The Risk Manager will randomly monitor 10 residents per week to assure safety devices are in place. The DON or designee will monitor compliance weekly for 4 weeks during weekly focus meeting. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	5-19-12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place for one (#81) of thirty-four	F 323		

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F 323	Continued From page 29 residents reviewed. The findings included: Resident #81 was admitted to the facility on March 8, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, and Mental Disorder. Medical record review of a fall risk assessment dated March 2, 2012, revealed the resident was at risk for falls. Medical record review of the physician's orders dated April 2012 revealed "...Body clip alarm while up in...chair at all times..." Observation and interview on April 17, 2012, at 4:20 p.m. with the East Unit Coordinator revealed the resident seated in the chair in front of the nursing station without the body clip alarm in place.	F 323	F-364 Dietary Manager discussed appropriate food temperatures with residents #78 and #96 and communicated departments plan for continued compliance. Interviews were conducted by Dietary Manager or Designee with other residents to identify any additional concerns with food temperatures and no other issues were identified. The Dietary Manager will complete temperature audits on test trays daily 5 times a week to ensure all food is served at the appropriate temperature. All staff members will be re-educated regarding the importance of timely delivery of each meal tray. The Dietary Manager and/or the DON will observe tray delivery process at random meals for 4 weeks then monthly thereafter. Results will be discussed for 3 months in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	5-19-12
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview the facility failed to provide food served at the proper temperature for two (#78, #96) of thirty-four residents reviewed.	F 364		

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F 364	Continued From page 30 The findings included: Observation with the Dietary Manager on April 18, 2012, at 12:00 noon, in the Dietary Department, revealed a test tray was requested, prepared, and placed on the food cart. Observation on April 18, 2012, at 12:27 p.m., in the Dining Room, revealed the last tray had been served from the food cart. Further observation at this time with the Dietary Manager revealed the temperature of the potato salad on the test tray was fifty-five degrees, broccoli salad was sixty degrees, and the pork was eighty degrees. Review of the facility policy Minimum Temperature at Point of Service dated February 7, 2011, revealed "...Hot Food > (greater) 120 F (Fahrenheit)...Cold Food < (less) 50 F..." Interview with resident #78 on April 16, 2012, at 11:05 a.m., in the resident's room, revealed the residents hot food was almost always cold and would rather eat it cold than have staff warm the food. Interview with Resident #96 on April 17, 2012, at 3:28 p.m., in the resident's room, revealed the residents hot food was served cold. Interview with the Dietary Manager on April 18, 2012, at 12:40 p.m., in the dining room, confirmed the facility failed to provide food served at the proper temperature.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 31 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy the facility failed to maintain proper sanitation and safe temperatures in the dietary department. The findings included: Observation and interview on April 17, 2012, at 11:30 a.m., with the Dietary Manager, in the Dietary Department, revealed two trays of ten eight ounce glasses of milk sitting out and ready to be served. The temperature of one labeled thick was fifty degrees. Interview at this time with the Dietary Manager confirmed the safe temperature is forty-one degrees or lower and the milk was at an unsafe temperature and available for resident use. Observation and interview on April 17, 2012, at 11:45 a.m., with the Dietary Manager, in the Dietary Department, revealed three pieces of baked chicken on the steam table in the pan with other breaded chicken pieces. The temperature of the chicken was 100 degrees. Interview with the Dietary Manager confirmed the safe	F 371	F-371 Dietary Manager was re-educated by Dietitian regarding food storage, preparation, distribution, and hand-washing policy. All food service staff was re-educated by staff development coordinator related to food storage, preparation, distribution, and hand-washing policy. The Dietary Manager will complete random temperature audits during meal service daily 5 days a week to ensure all food is at the appropriate temperature for 30 days. The Dietary Manager or designee will observe at random meals food service prep and delivery for compliance. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	5-19-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 32 temperature is 140 degrees and the chicken was at an unsafe temperature and available for resident use. Observation and interview on April 18, 2012, at 11:35 a.m., with the Dietary Manager, in the Dietary Department, revealed the Dietary Manager washed the hands and removed the lid of a twenty five gallon grey trash can and disposed of the paper towel. Further observation at this time revealed the Dietary Manager immediately started preparing milk products for resident consumption. Review of facility policy Handwashing and Hand Hygiene dated December 1, 2010, revealed "...examples of when hand hygiene is indicated...after touching a source that is likely to be contaminated...waste receptacles..." Interview with the Dietary Manager on April 18, 2012, at 11:40 a.m., in the Dietary Department, confirmed proper hand washing was not followed. Review of facility policy Tray Line and Meal Service Temperatures no date revealed "...all hot food must be held at temperatures above 140 F (farenheit)...all cold foods will be held at or below 41 F..." Observation and interview on April 19, 2012, at 11:30 a.m., with the Dietary Manager, in the Dietary Department, revealed one tray of eight six ounce bowls of puree potato salad. The temperature of the puree potato salad was 45 degrees. Interview with the Dietary Manager confirmed the safe temperature is forty one degrees or colder and the potato salad was at an	F 371		

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F 371	Continued From page 33 unsafe temperature and available for resident use.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	**F-441** The residential washing machine has been removed from the soiled linen room. The Maintenance Director and Infection Control Nurse have examined the facility and no other issues were identified. The Infection Control Nurse will make rounds weekly to ensure continued compliance in the soiled linen room. The DON or designee will observe soiled linen room monthly for 3 months. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance. **F-464** Resident #174 has been provided appropriate furnishings for comfortable dining. All other residents were assessed for appropriate furnishings for comfortable dining and no other residents were identified. The Restorative Nurse will observe the seating in the dining room to ensure each resident has access to appropriate furnishings for comfortable dining for 4 weeks	6-3-12 5-19-12

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F 441	Continued From page 34 infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview the facility failed to follow infection control practices in the Laundry Department. The findings included: Observation with the Maintenance Director on April 19, 2012, at 9:15 a.m., in the soiled linen room, in the laundry department, revealed a small washing machine. Review of the facility policy Laundry and Linen dated June 2010, revealed "...separate soiled and clean linen at all times..." Interview with the Housekeeping Supervisor on April 19, 2012, at 9:15 a.m., in the soiled linen room, confirmed the small washer was used for the resident's personal laundry. Interview with the Nursing Home Administrator (NHA) on April 19, 2012, at 10:35 a.m., in the NHA Office, confirmed that the small washer should not be in the soiled linen room and soiled and clean linen should be separated.	F 441	The DON or designee will randomly observe for compliance of appropriate seating for 3 months. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	
F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well	F 464		

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F 464	Continued From page 35 ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to adequately furnish the Dining Room for one resident (#174) of thirty four residents reviewed. The findings included: Observation on April 18, 2012, at 12:30 p.m., in the Dining Room, revealed resident #174 in a wheel chair eating lunch. Further observation revealed the resident was unable to reach the plate due to the table being too high. Interview with the Director of Nursing on April 18, 2012, at 12:30 p.m., in the Dining Room, confirmed the resident was unable to reach the food and needed a table that was lower.	F 464	F-502 A Dilantin level for resident #81 was obtained on 4-18-2012. All other residents with scheduled labs were reviewed and no other missing labs were identified. The unit managers will complete weekly audits for all lab orders to ensure that they are completed as ordered. The DON or designee will monitor weekly for 4 weeks in the weekly focus meeting. Results will be discussed in the monthly Continuous Quality Improvement meeting comprised of the DON, Risk Manager, Medical Director, Social Services Director, Dietary Manager, Rehab Director, Staff Development Coordinator, Admissions Director, Activities Director, Restorative Nurse, Wound Care Nurse, Director of Medical Records and Administrator for Quality Assurance.	5-19-12
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to obtain a laboratory test for one (#81) resident of thirty-four residents reviewed.	F 502		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH CARE CENTER	100 ELMHURST DR OAK RIDGE, TN 37830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 36 The findings included: Resident #81 was admitted to the facility on March 8, 2011, with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, and Mental Disorder. Medical record review of a physician's order dated March 23, 2012, revealed "...(increase) Depakote 500mg (milligrams) po (by mouth) q (every) am, 250mg po q 3 pm, (and) 500mg po q hs,(bedtime)...Depakote level in 1 wk (week)..." Interview on April 18, 2012, at 8:45 a.m. with the East Unit Coordinator at the nursing station confirmed the Depakote level had not been obtained. Medical record review of a physician's order dated January 7, 2012, revealed "...Dilantin level..." Interview on April 18, 2012, at 8:55 a.m. with the East Unit Coordinator at the nursing station confirmed the Dilantin level had not been obtained.	F 502		